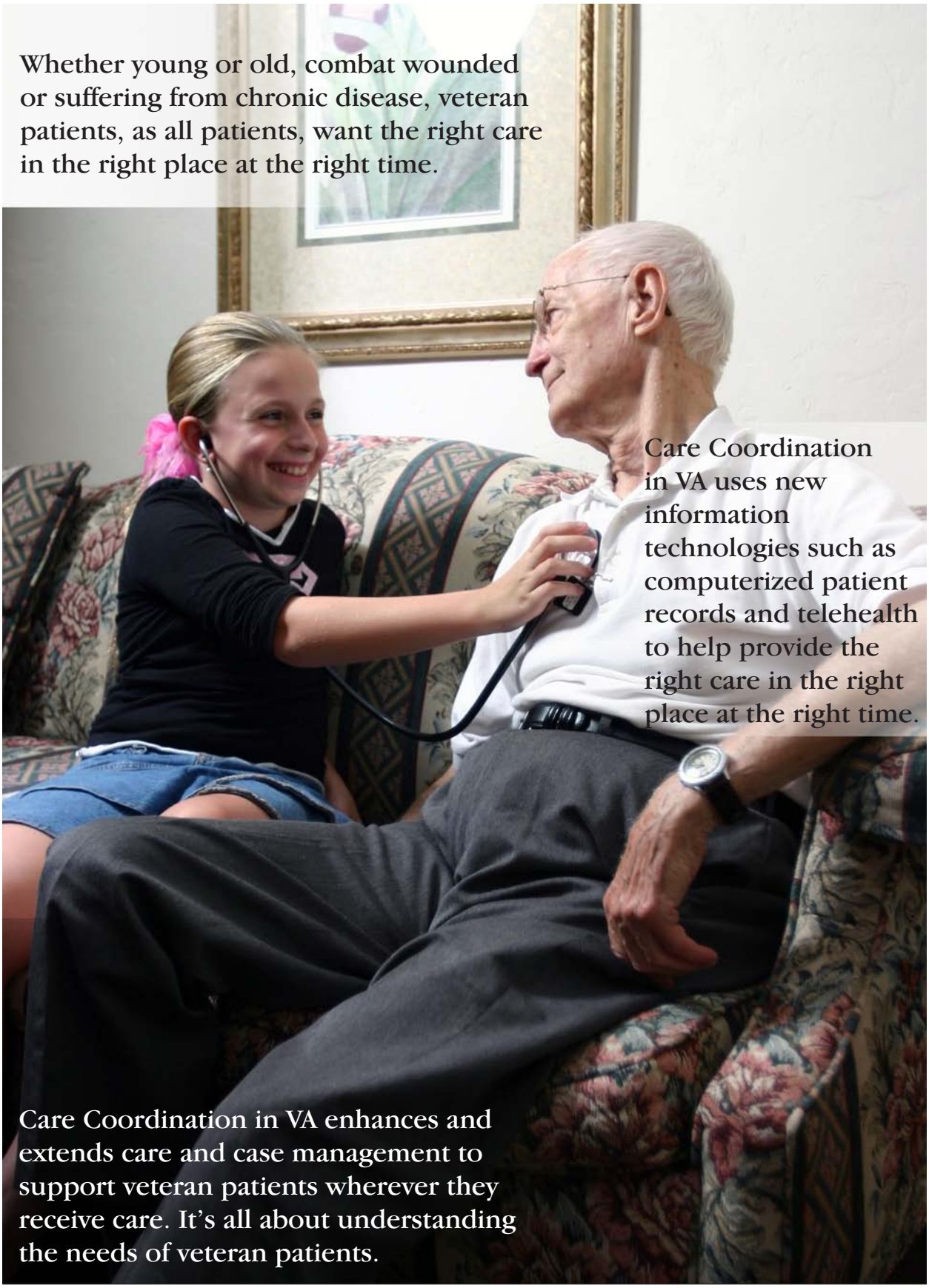
Care Coordination in the Department of Veterans Affairs

Providing the Right Care in the Right Place at the Right Time

Activities and Achievements 2003 - 2005

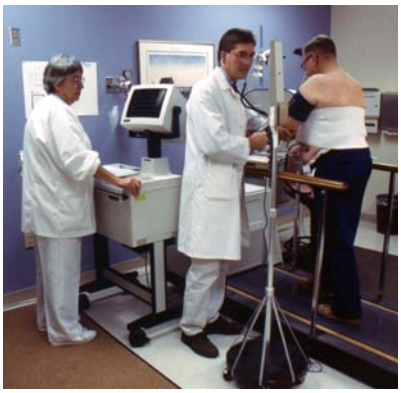
Whether young or old, combat wounded or suffering from chronic disease, veteran patients, as all patients, want the right care in the right place at the right time.



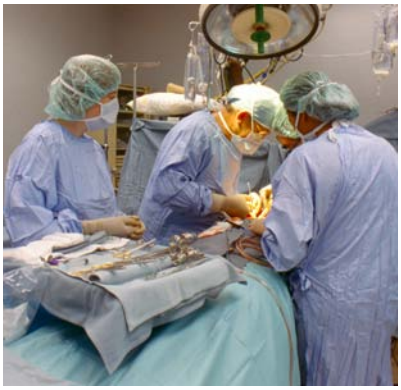
Care Coordination in VA uses new information technologies such as computerized patient records and telehealth to help provide the right care in the right place at the right time.

Care Coordination in VA enhances and extends care and case management to support veteran patients wherever they receive care. It's all about understanding the needs of veteran patients.

Introduction from Adam Darkins, Chief Consultant for Care Coordination



The Veterans Health Administration (VHA) provides care to over 5 million veteran patients each year in 153 hospitals (VA Medical Centers), over 1000 other sites of care and increasingly into the homes of veterans. The Office of Care Coordination was established by VHA in July 2003 within the Office of Patient Care Services, with the specific intent of helping do exactly what its name implies and support VHA in coordinating care in and between all the various places where it is being delivered by VHA's skilled and dedicated staff. Ideally every patient in every healthcare system, not just VHA would have a care manager to help manage their care.



This is neither practically nor economically possible in the current healthcare environment that is based upon the way things have always been done. New technologies are bringing great benefits to many areas of our lives and care coordination applies several of these technologies that blend health informatics (computerized patient records), telehealth and disease management to deliver care in revolutionary new ways. I am very proud to head a program office that is dedicated to supporting this noble endeavor in VHA. Ours is a collaborative effort involving people throughout the organization. We have not named particular individuals. Any kudos due to what has been achieved is due to the efforts of the many and no one individual. Where kudos is appropriate, it is because of the difference that has been made in the delivery of care to veteran patients. This report will therefore focus on the care delivered and how this is done. If you have questions, queries or comments about Care Coordination in VHA please contact us at www.va.gov/occ.

Contents

1. What is care coordination and why coordinate care?

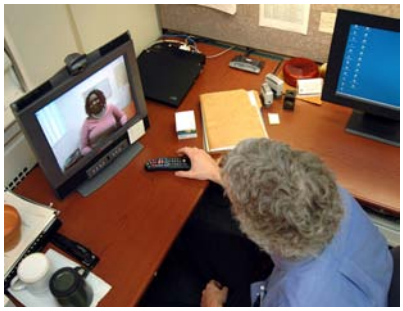
Care coordination in VHA takes place in 3 ways (1) In veteran patient's homes using home telehealth technologies. This is called care coordination home telehealth (CCHT). (2) Between hospitals and clinics and other VA sites of care through the use of videoconferencing technologies. This is called care coordination general telehealth (CCGT). (3) By sharing digital images (e.g., photos of the retina to screen for diabetic eye disease) among VA sites of care through data networks. This is called care coordination store-and-forward (CCSF).

2. Care Coordination Home Telehealth (CCHT)

Veteran patients with chronic diseases such as diabetes, heart failure and chronic pulmonary disease can be monitored at home using home telehealth technologies. This prevents or delays an elderly veteran needing to leave their home and move into long-term institutional care unnecessarily.

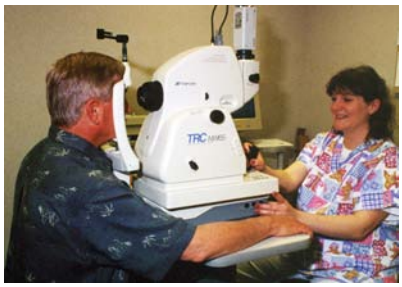
3. Care Coordination General Telehealth (CCGT)

VHA has opened community-based outpatient clinics (CBOCs) to make services more readily accessible to veteran patients, especially in rural areas. Videoconferencing technologies and diagnostic equipment mean specialists from major hospital centers can review veteran patients in a CBOC close to home avoiding travel and offering easier access to specialist care.



4. Care Coordination involving Store-and-Forward (CCSF)

When it's necessary to make some diagnoses and recommend treatment, there are some areas of care where a picture says a thousand words. VHA is using digital imaging to provide wound care, check for diabetic eye disease and deliver dermatology care in rural areas.



5. Social Work's vital role in care coordination in VHA

Taking care into the home and local community for veterans is very different from caring for people in the hospital. VHA's role is essentially inverted from that of "host" to "guest." For CCHT, VHA Social Work helps facilitate this transformation primarily by addressing the psycho-social aspects of care that are so important to good health.

SECTION 1. What is care coordination and who coordinates care in VHA?

Care Coordination in VHA is: "the use of health informatics, disease management and telehealth technologies to enhance and extend care and case management to facilitate access to care and improve the health of designated individuals and populations with the specific intent of providing the right care in the right place at the right time."

The hospital is not always the best place to care for people with chronic diseases like diabetes, heart failure, post-traumatic stress disorder, and pulmonary disease. Veterans would like care in their local community but also want the excellence of care that VHA is now recognized as providing[1]. Telehealth makes it possible for VHA to bring specialist care directly into the home and the local community. Instead of veteran patients having to travel to get care, the care they need is often able to come to them.

As veterans age and need treatment for chronic diseases, the care they need is changing. They continue to need acute hospital care from time to time, as they did when they were younger. Very rarely is the care of chronic disease a "quick fix," after which all is well. Living with chronic disease affects a person's way of life and their family as well. Caring for chronic disease involves more than the episode of care in the hospital or the visit in the clinic. It involves the patient and the community in which they live.

[1]Institute of Medicine

Care Coordination in VHA is based upon the principles of the Chronic Care Model of Disease

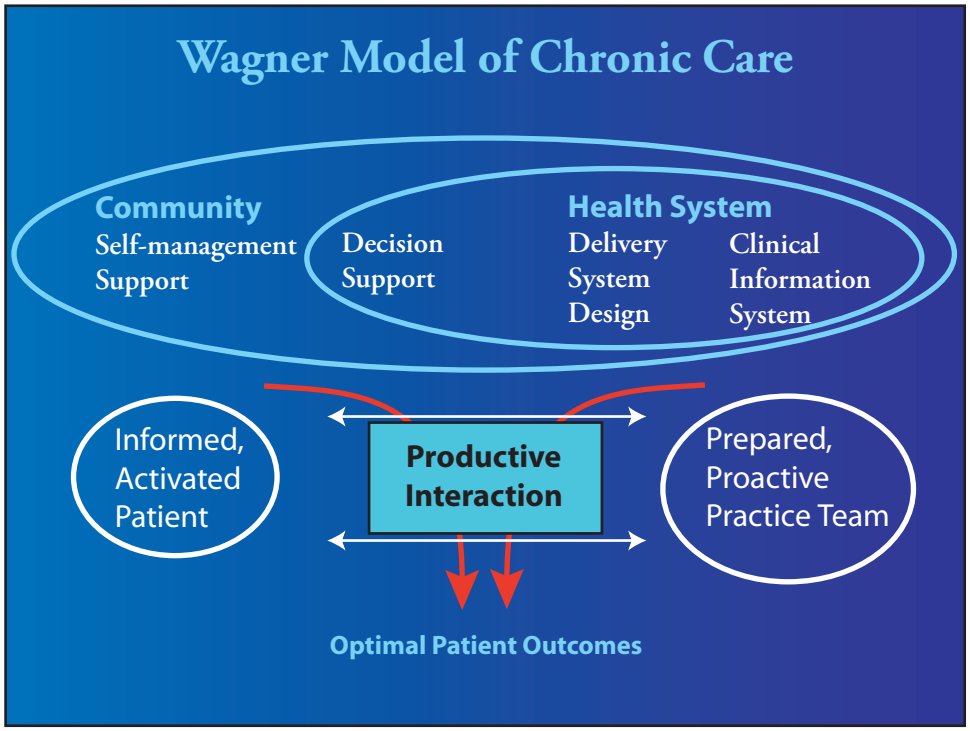


Figure 1. Used by permission: E. H. Wagner, "Chronic Disease Management: What Will It Take to Improve Care for Chronic Illness?," *Effective Clinical Practice* 1998; 1: 2-4

The Chronic Care Model

The Chronic Care Model is a new approach to care that creates mechanisms whereby the functional and clinical outcomes achieved by patients are improved by changing the interactions between patients and providers by:

- Using clinical information systems for population tracking, care reminders, and improved treatment planning
- Making effective treatment decisions through evidence-based guidelines or new models of specialist support
- Re-engineering care delivery systems that give practice teams the resources, methods, and time to plan, interact, and follow up productively with patients
- Engaging patients in managing their own conditions
- Aligning healthcare systems to support chronic care
- Accessing community resources to support patients and practitioners

SECTION 2. Care Coordination/Home Telehealth (CCHT)

The complexity of managing chronic conditions means that many elderly people have to give up living independently and move into long-term institutional care. In some cases this is entirely appropriate. However, CCHT can make the home into the preferred place of care.

Following a successful pilot in VISN 8 between 2000 and 2003, VHA launched a national care coordination program in July of 2003. This program supports veteran patients with chronic diseases such as diabetes, heart failure and Post Traumatic Stress Syndrome to remain in their own homes and receive non-institutional care based upon home telehealth technologies. Table 1 shows the growth in patient census from July 2003 to September 2005 during which time the number of VISN with CCHT programs has grown from 5 to all 21 VISNs.

Number of Patients in CCHT Care 2003 - 2005 and Projected 2006

Sept. 2003	Sept. 2004	Sept. 2005	Sept. 2006 (Projected)
1,700	4,000	9,000	21,000 - 25,000

Table 1

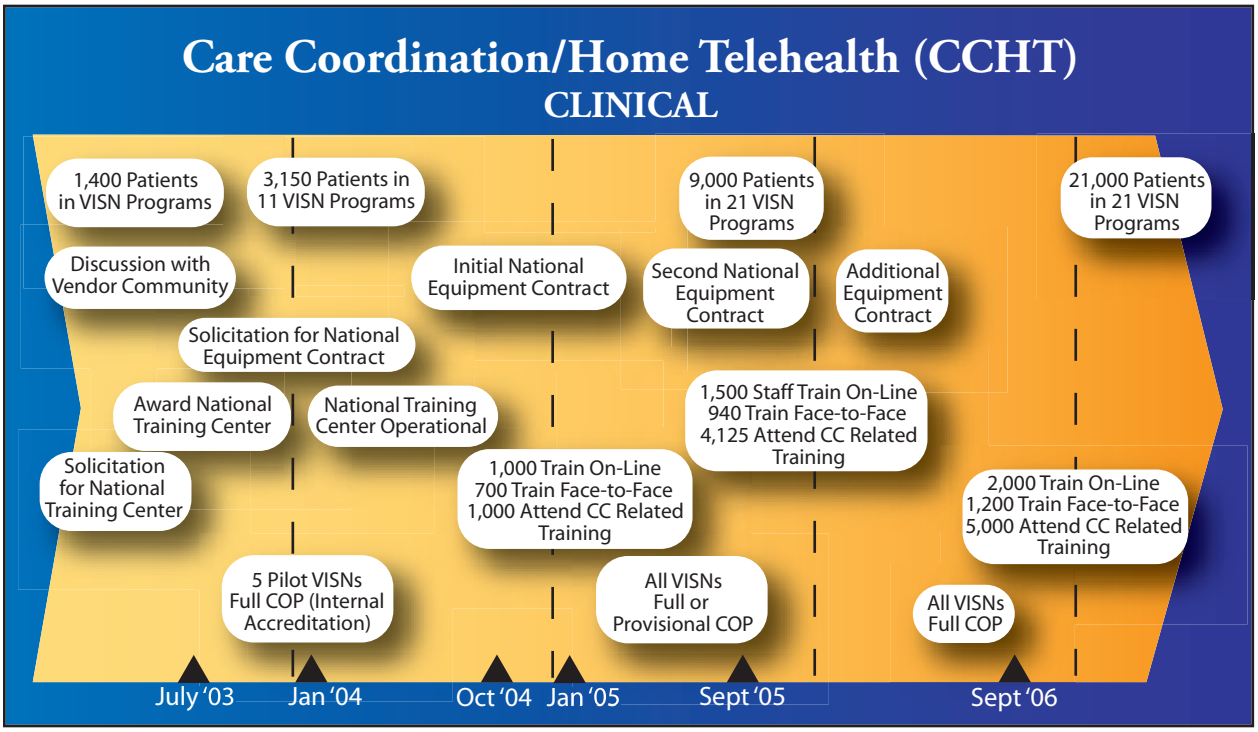


Figure 2

VISN CCHT Activity as of End of FY05 and Average Daily Census (ADC)

VISN	Patient ADC '05	Patient Census Sept. '05
1	237	193
2	286	591
3	14	223
4	49	273
5	80	234
6	7	146
7	138	566
8	1155	2137
9	24	545
10	83	537
11	167	352
12	13	139
15	25	187
16	14	154
17	92	161
18	76	421
19	321	825
20	102	198
21	31	244
22	191	648
23	22	47

Table 2

The home telehealth technologies used for CCHT include messaging devices that deliver and receive disease management dialogues from patients directly from their homes each day, videophones and video monitoring devices. Patients are selected for a particular technology using an algorithm that matches the complexity of their disease to the level of sophistication of the home telehealth device.

Care Coordinators

Each patient being supported by CCHT has a care coordinator. The care coordinator is usually a nurse practitioner, a registered nurse or a social worker but can be any practitioner. There are physicians who care coordinate complex patients such as those with complicated heart failure. A care coordinator can manage between 90 and 150 patients depending upon the complexity and nature of the chronic disease.

Employee Education System

In January 2004, VHA established a CCHT training center in Lake City, FL. This training center has trained over 2,000 staff in care coordination since it was established. Working closely with VHA's Employee Education System (EES), a curriculum for CCHT with five modules has been developed. EES supports VHA's CCHT training center by using both new and traditional media to distribute the content of the training materials that are produced.

The Growth in Numbers of Care Coordinators Trained Between January 2004 and October 2005

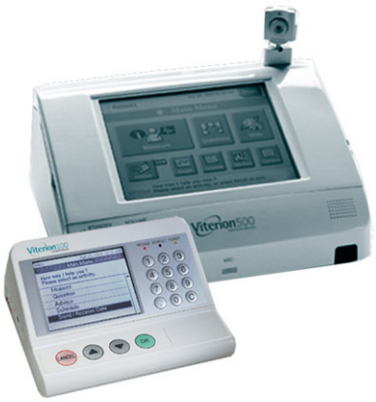
Initial		Cumulative	
Jan 04 - Oct 04		Oct 04 - Oct 05	
Face-to-Face Training	**Virtual Training**	**Face-to-Face Training**	**Virtual Training**
700	1,000	940	1,500

Table 3

CCHT Technology

VHA's Care coordinators are able to monitor their patients by viewing the data from the various technologies on computers. They can contact the veteran patient by telephone if the information from the home shows there is a reason for concern. CCHT patients do not have acute conditions. It is only suitable for patients with chronic conditions that may deteriorate over a period of days. If such patients have an acute exacerbation, they are seen using the normal urgent review/admission channels.

National CCHT Equipment Contracts



In order to standardize the interface with VHA's computerized patient record (CPRS), expedite contracting and obtain volume discounts, VHA has awarded national contracts with four vendors for home telehealth messaging devices, four vendors for tele-monitoring devices and a single vendor for videophones. OCC has worked with the Office of Prosthetics and Sensory Aids and VHA's National Acquisition Center to accomplish this.

Privacy and Confidentiality

The security of patient information is of paramount concern to VHA. OCC has worked with the Office of Information in VA to ensure that cyber security and other privacy and confidentiality requirements are all met. Figure 3 shows how a double firewall is in place to protect patient information.

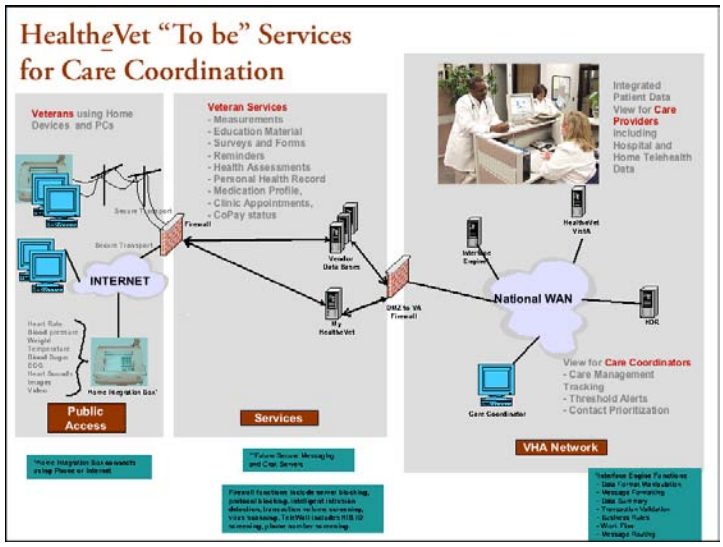


Figure 3

VHA's National CCHT Information Technology Infrastructure

VHA's Office of Information is also supporting OCC in developing a highly sophisticated electronic process for the referral of patients for CCHT and the associated data transfers necessary to provide information to practitioners. Providing the right care in the right place at the right time requires the right information. Figure 4 describes the data flows that are under development. VHA is helping establish the Health Level 7 (HL-7) data standards in this new area of care provision in the process.

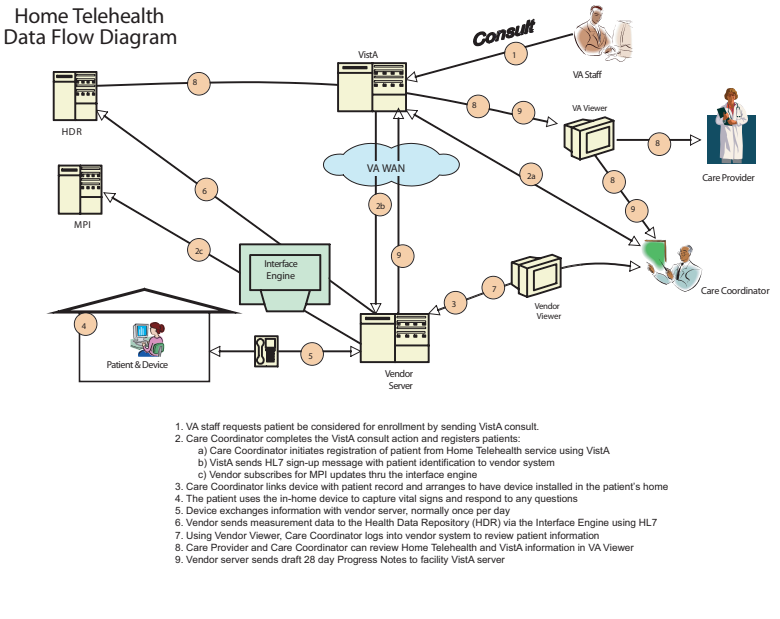


Figure 4

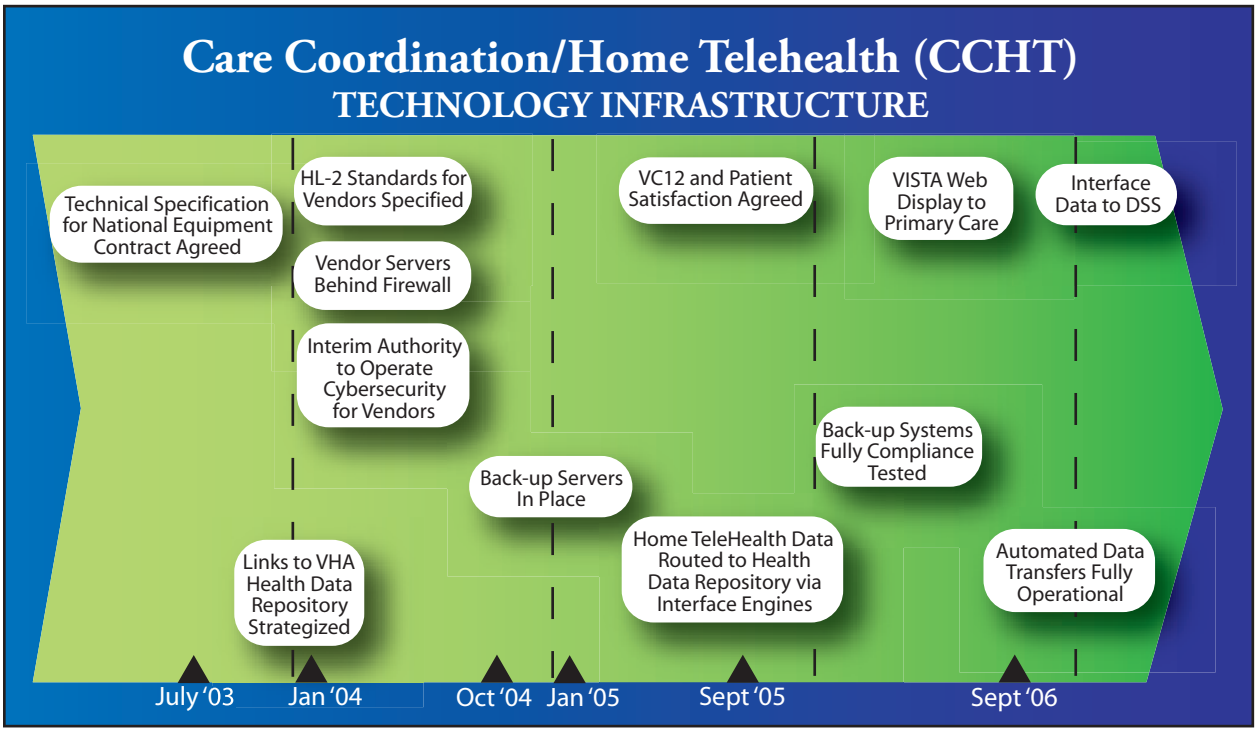


Figure 5

Ensuring the Quality of Care Provided via CCHT

VHA was recently recognized as providing the "best care anywhere."[2] VHA is committed to delivering and excellence of care to the veteran patients it serves. OCC has developed a comprehensive quality assurance program for CCHT. This includes each VISN CCHT program having to satisfy its "conditions to participate" (an internal VHA accreditation program). To date, all 16 VISNs that have been reviewed have satisfactorily received this status. In conjunction with VHA's Office of Information and the MVP data group (see later) OCC has developed a data cube that will provide comprehensive outcomes information on CCHT. See Figure 6 for an example of outcomes information obtained for CCHT using the cube.

VHA Patient Population in CCHT Programs by Age Range - FY2005

Age in Years	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90-99	>99
Percentage	0.16	1.17	5.95	23.77	21.86	27.7	18.26	1.11	0.006

Figure 6

[2]Phillip Longman, "The Best Care Anywhere," Washington Monthly 2005; 1:12

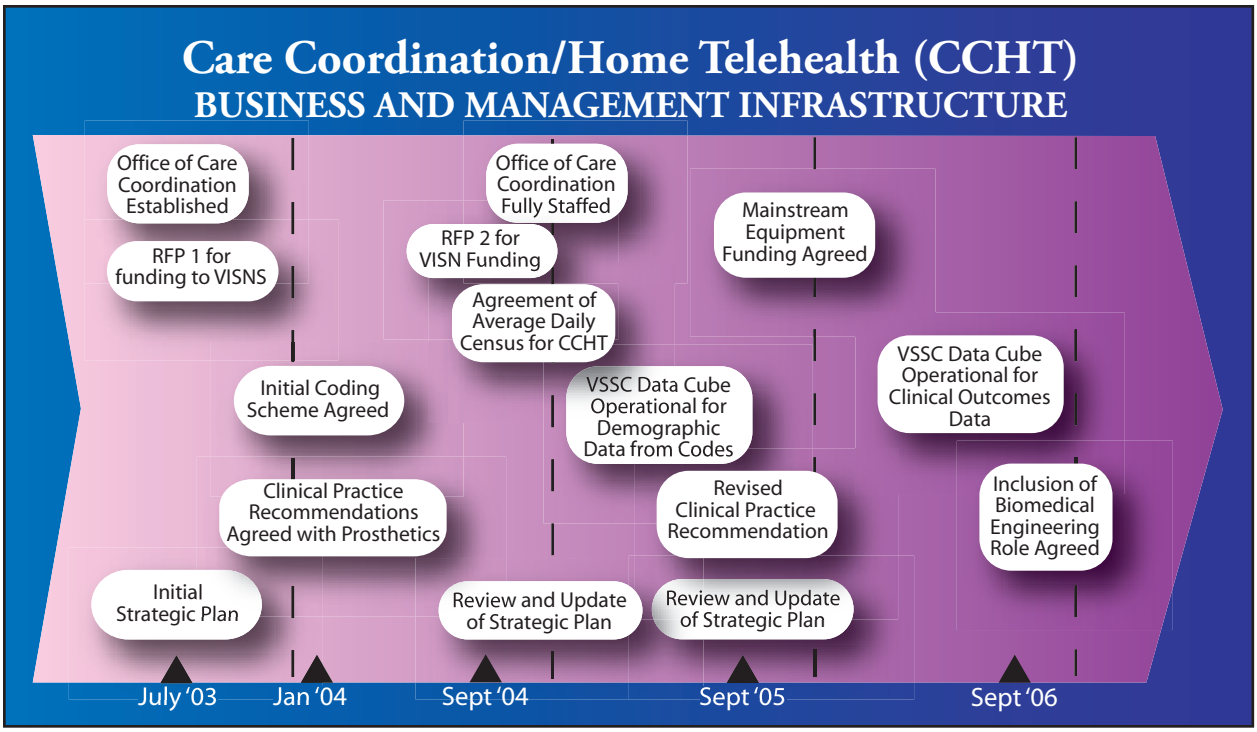


Figure 7. A vital part of incorporating CCHT into routine clinical practice is to ensure that the appropriate business practices and management structures are in place. Figure 7 outlines the sequence of their development.

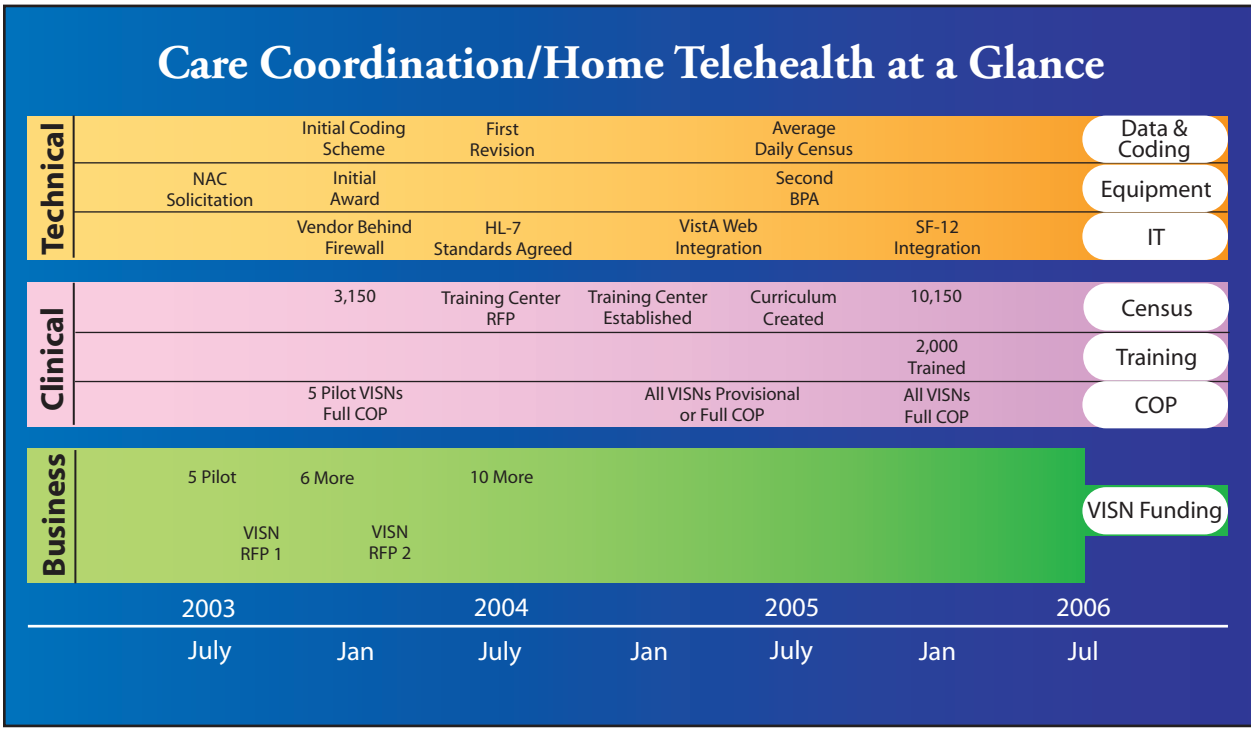


Figure 8 shows how the clinical, technical and business elements all come together.

Ongoing Quality Improvement

CCHT in VHA is at the leading edge of health care development and is a work in progress that is based upon a model of continuous quality improvement. The initial model of CCHT that was developed in VISN 8 between 2000 and 2002 was refined in VISNs 1,2,11 and 17 in 2002 prior to the national program rollout. Figure 9 shows how having defined the model, VHA is implementing, evaluating, critically reviewing the model and then re-implementing it.

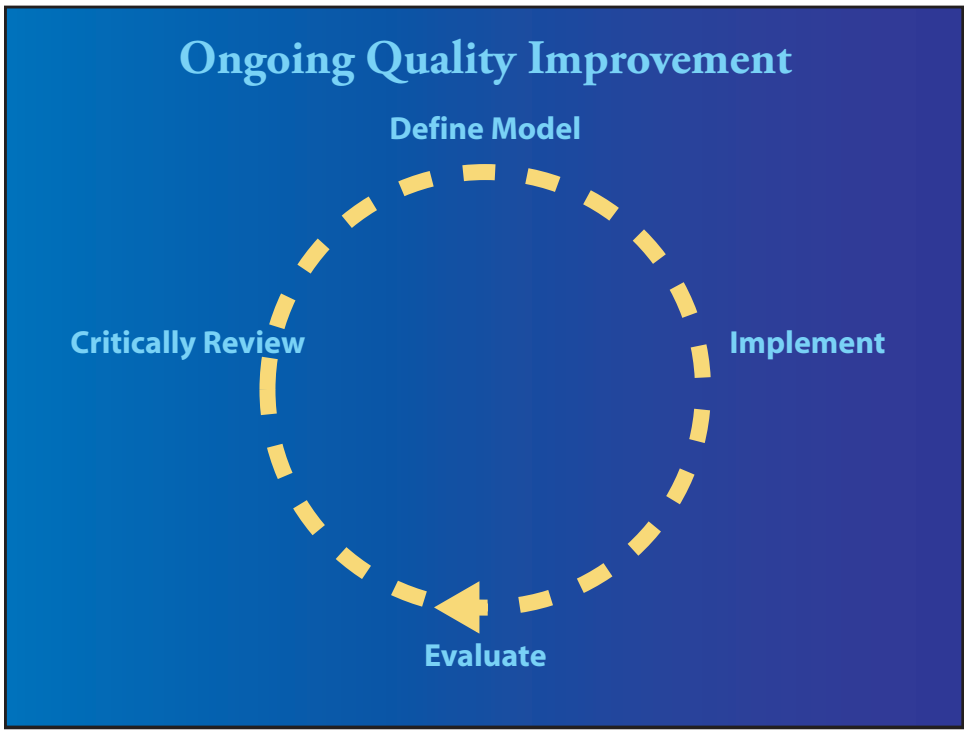


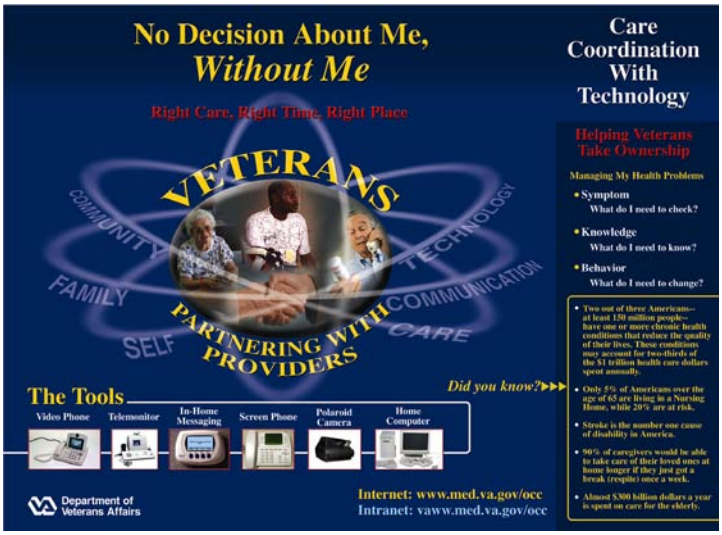
Figure 9.

The Devil is in the Detail and the Strength is in the Grass Roots

The vision of CCHT and supporting care in the home is relatively easy to grasp. The devil is in the detail of making it happen. For OCC to make the necessary changes in the implementation of CCHT it is vital that the program is grounded in the clinical delivery of care to patients. OCC has program development, quality and business staff 50% employed by VA Central Office and 50% in VISN programs. This staff is able to give vital perspectives of the ongoing refinement of the model of care coordination. OCC is also very fortunate to have VISN leads for CCHT in each VISN that actively participate in bi-monthly meetings (MVP-leads group) and data leads (MVP data group) who support OCC in developing the workload, outcomes and research data resources to evaluate the programs. In conjunction with VHA's Decision Support System (DSS) OCC has developed a comprehensive coding mechanism that records CCHT workload.

Patient Self-Management

A vital part of CCHT is patient self-management. The partnership that CCHT in VHA is aimed to foster is exemplified by the information to patients that exhorts "no decision about me without me."

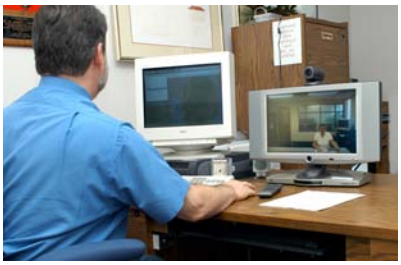


The Caregiver in the Home – the Vital Link to Care

VHA is aware that of all the partnerships and collaborations that are necessary to CCHT the one that hold everything together is often the caregiver in the home. With this in mind OCC has a staff member devoted to caregiver support issues and convenes an annual conference dedicated to the caregiver, to which national caregiver organizations and other federal agencies are active participants.

OCC is engaged in assessing caregiver support and actively trying to find ways to connect caregivers in the home with community resources. It may well be that a crucial determinant of a successful outcome when using CCHT is a supportive caregiver in the home who is able to cope and not subject to avoidable burn out.

SECTION 3. Care Coordination/ General Telehealth (CCGT)



VA's health care system includes 153 medical centers, with at least one in each state, Puerto Rico and the District of Columbia, and operates more than 1,300 sites of care within the United States. More than 5 million veterans will receive care in VA health care facilities in 2005. The majority of consultations that take place will be traditional face-to-face ones. But, given the distances veteran patients sometimes have to travel, telehealth is a way to improve access, expedite specialist opinion and save the inconvenience and cost of travel.

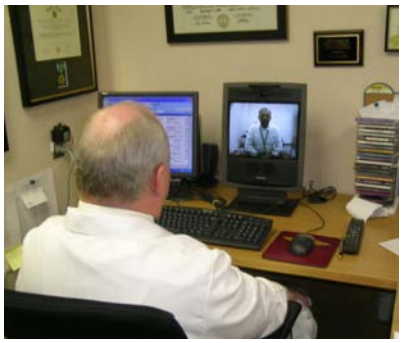
Telehealth involves the use of clinical video-conferencing systems that make it possible for a specialist clinician, e.g. a psychiatrist or surgeon to see a veteran patient who may be hundreds of miles away.

As well as the time, distance and cost there are also the questions of weather and traffic conditions that affect whether both veteran patients and staff are able to get to clinics. Telehealth means that services can travel to the veteran, rather than the veteran having to travel to the services.

As veteran patients age finding their way to the hospital is not always easy and straightforward.

Areas of Care Provided via Care Coordination/ General Telehealth in VHA Include the Following:

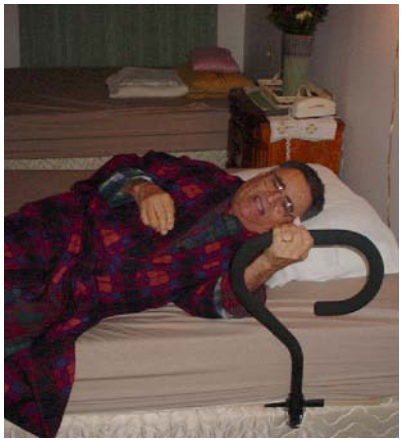
Telemental Health: This is a major area of health need that VHA addresses, not only for existing veterans but for those returning from Operations Enduring Freedom and Iraqi Freedom. Telemental Health in VHA currently takes place in 228 sites of which 120 are community-based outpatient clinics (CBOC's), 74 are VA Medical Centers (VAMC's), 20 VET Centers and 14 support home-telehealth. Direct care in FY04 was provided to over 9,750 veteran patients with mental health conditions and they received more than 20,000 consultations.



For a veteran in Caribou, Maine, to travel down state to the nearest VA Medical Center in Togus is a 249 mile trip in each direction. The normal seasonal snowfall is nine and a half feet. Even if it doesn't snow it is a 10-hour round trip and there is also the cost of the gasoline for the veteran patient.

Care Coordination/General Telehealth makes it possible to get a mental health consultation for a veteran from the CBOC in Caribou and avoid the inconvenience and cost of travel. In the words of one veteran, "thank God there's telehealth."

Telerehabilitation: Veterans with chronic conditions often have problems with mobility that adds to their difficulties in traveling to get care. Telehealth means that patients can get support close to their own homes. VHA has two national centers for multiple sclerosis care that are seeking to use telehealth to help with ongoing treatment and symptom management. Similar regional models exist with some of VHA's Spinal Cord Injury/Disorder Services. Telerehabilitation and Polytrauma Centers is discussed below under Upcoming Developments for Combat Wounded.



Telehealth for Management of Infectious Disease: In a world where air travel means travel between continents is commonplace, microorganisms don't respect the fact that there may be no specialist expertise in a remote VA Medical Center to assess a patient with infectious disease. Telehealth provides a solution.

Telehealth in Other Clinical Areas: Telehealth in VHA covers 33 clinical specialties and includes surgery, speech therapy, cardiology, neurology, neurosurgery, transplantation, and others.

Telehealth in Rural Areas: Increasingly rural VA Medical Centers rely on telehealth to provide services. Iron Mountain VAMC was a pioneer of telehealth in VHA during the 1990's. Telehealth has helped in maintaining services that would otherwise have been difficult to sustain. CCGT care involving pathology, radiology and mental health have all been supported using telehealth http://www.visn12.med.va.gov/IronMountain/ABO/.

Traveling around the world and back by telehealth

Poplar Bluff VA Medical Center in Missouri estimates that telehealth has saved the need for over 56,000 miles of patient and staff travel (around the world and back again). The range of Poplar Bluff telehealth activities include areas such as: dermatology, cardiology, retinal imaging, major medical evaluation, pain management, radiology, speech therapy physical therapy, mental health services, substance abuse treatment programs, multi-point patient education for diabetes, multi-point patient education for congestive heart failure, smoking cessation, pharmacy education, distant staff education and care coordination/home telehealth. Having these programs means patients can receive prompt, effective care within their own home or local community. Access to specialty care clinics from CBOCs via telehealth is resulting in a 30% lower no show rate in mental health clinic compared to when the clinics required travel for face-to-face appointments.

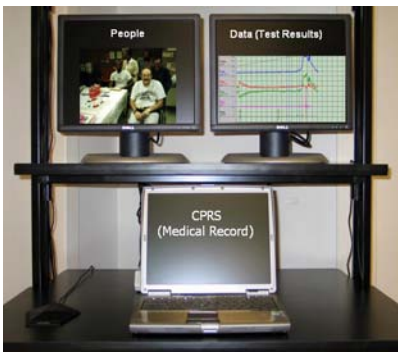
Standardization and VHA Leads for CCGT and Telehealth Toolkits

VHA has the potential to develop a large national telehealth network to provide veteran patients with an unparalleled standard of care. It's possible that a veteran patient in rural Michigan, Maine or Montana could link with a VA cardiologist in New York or California who is a world expert in a particular clinical problem. To assist in the development of telehealth and to help standardize clinical processes and the technology to support these clinical processes, VHA has lead clinicians for CCGT in the following areas:

- Telemental Health
- Telerehabilitation
- Telesurgery

VHA has developed toolkits in all these areas and they are available on VHA's Care Coordination website: http://www.va.gov/occ. The toolkits have been developed for the VHA environment, which has some unique characteristics and therefore, if used elsewhere, they need to be appropriately tailored.

Health Informatics and Telehealth



Making telehealth work as a tool that delivers safe, clinically effective and cost-effective care involves much more than just the video and telecommunications technologies that are needed to support it. The patient's medical record, tests, laboratory results and radiological images are needed if vital decisions about care are to be made using telehealth.

VHA's unique computerized patient record provides the needed information to provide care. In VHA, telehealth involves the use of a multi-media patient record. Clinical processes such as credentialing and privileging and business processes such as workload coding have all been addressed by OCC to ensure that CCGT is part of the routine delivery of care and not a series of projects that are dissociated from the day-to-day provision of care. VHA's introduction of telehealth makes business sense as well as clinical sense and enhances patient care. Over 50 peer-reviewed journal articles from VHA clinicians and researchers have contributed to the evidence-base for the use of telehealth.

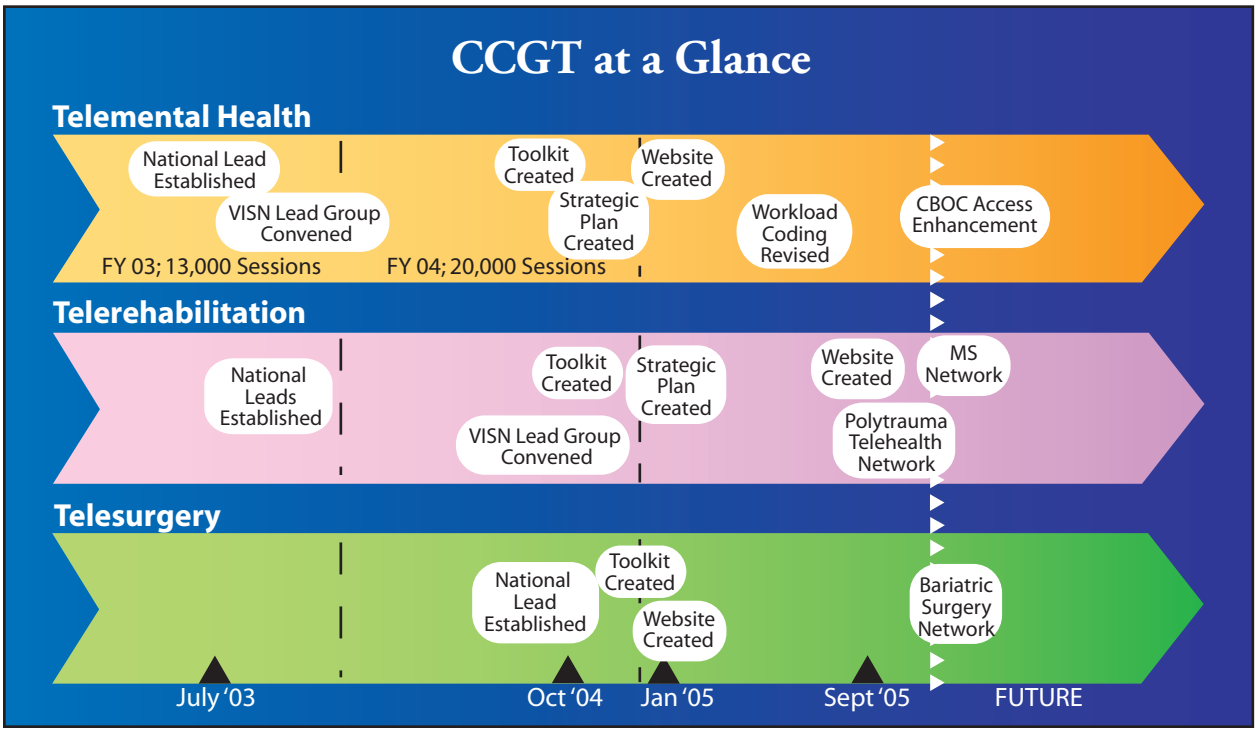


Figure 10

Upcoming CCGT Developments:

Combat Wounded: VHA is meeting the challenge of a new generation of heroes who are returning from current conflicts. The nature of their injuries is different because of the use of protective body armor. VHA has established four national polytrauma centers to deal with those with multiple traumas that include amputation, blast injury, head injury, spinal cord injury and post-traumatic stress disorder (PTSD). In 2006 VHA will develop a national polytrauma telehealth network (PTN) that will link VHA's four Level 1 polytrauma centers with 17 Level 2 polytrauma centers. The PTN will provide an unparalleled nationwide teleconsultation network to support the care of wounded veterans as close to their homes as possible and deliver state-of-the-art care.

Mental Health to CBOCs: From FY06 through FY 08 VHA has a major initiative to use telehealth to provide group clinics and specialist mental health services for PTSD and substance abuse into CBOCs.

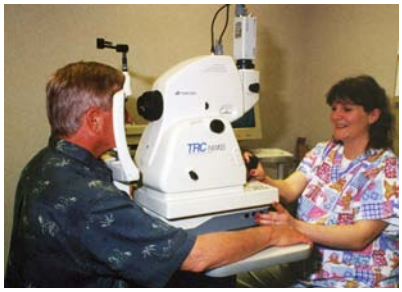
Training: In FY06 VHA will open a national CCGT Training Center in Salt Lake City, UT

Section 4. Care Coordination Using Store-And-Forward Technology

Store-and-Forward Technologies

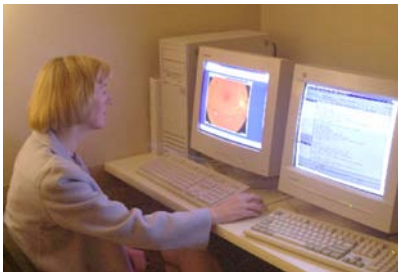
Sometimes a good clinical image is what is needed to screen for a condition or to make a diagnosis, manage and treat a condition. Twenty percent of veteran patients seen by VHA have diabetes. VHA currently exceeds the private healthcare sector in its ability to screen for diabetic eye disease (diabetic retinopathy). Advances in digital retinal imaging make it possible to screen for diabetic retinopathy using store-and-forward telehealth technologies.

Programs within VHA and collaborative arrangements with other federal and private sector organizations have substantiated the role for this technology in the delivery of routine care.

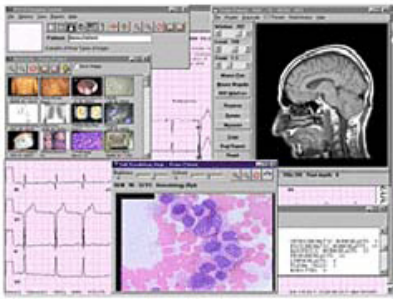


Between FY06 and FY08 VHA is undertaking a widespread implementation of teleretinal imaging to screen for diabetic retinopathy. At the end of the first year of full operation 75,000 veterans will receive care in this manner. At the end of the 2nd year of full operation this number is expected to reach 150,000 patients per year.

A dedicated implementation team will assist with the implementation of this program and VHA has established a national teleretinal imaging training center in Boston, MA to train the image acquisition technologists and image readers to support this program.



Just as the ability for VHA to undertake an enterprise implementation of CCHT and CCGT is, in part, dependent upon having a computerized patient record, so too is the implementation of teleretinal imaging dependant upon the information technology architecture of VistA Imaging in VHA.



With pending enhancements VistA Imaging enables the enterprise exchange of clinical images as part of the routine clinical workflow associated with the use of the computerized patient record.

This unique information technology architecture of VistA Imaging will also support the development of dermatology, wound care and telepathology programs in FY 2006-8.

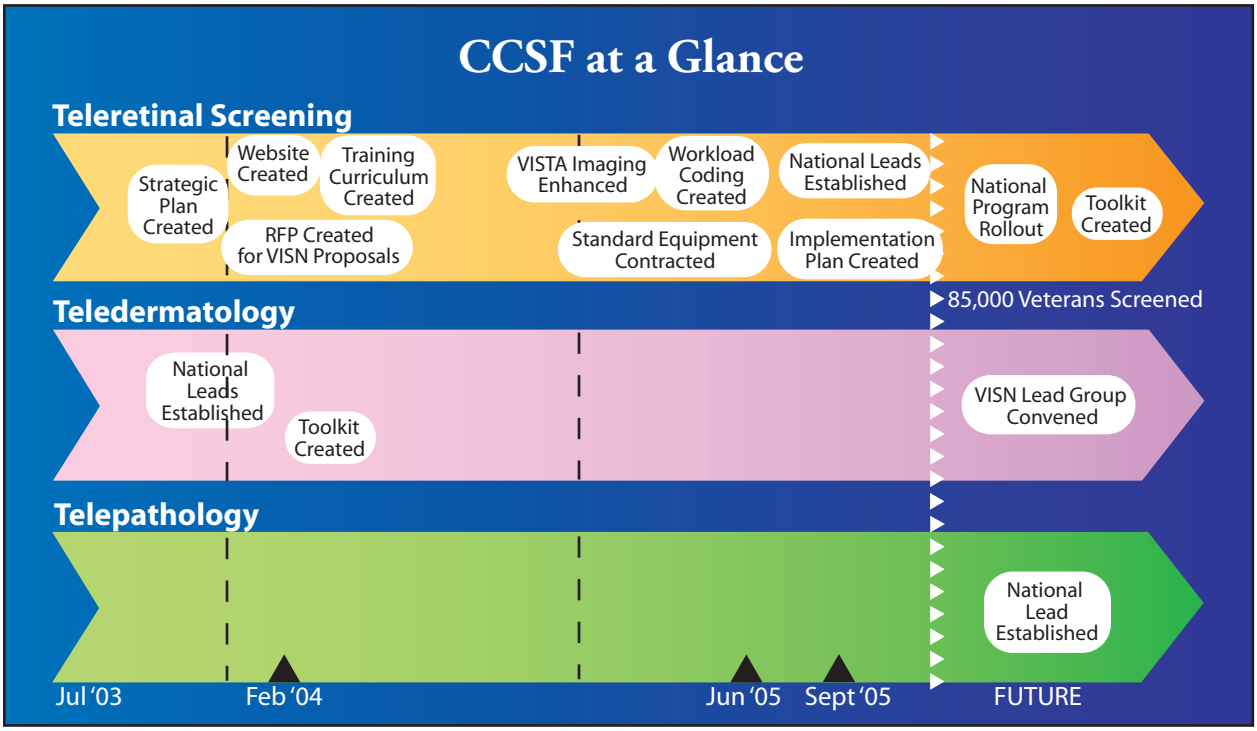


Figure 11

Section 5: Social Work's Vital Role in Care Coordination in VHA

VHA is the largest employer of master's prepared social workers in the United States. More than 4,100 social workers provide psycho-social, case management, care coordination and mental health services to veterans in VHA medical centers, community-based outpatient clinics, and home and community-based programs. VHA also trains more social work graduate students than any other single agency. Between 600-700 MSW students complete internships at VHA facilities each year, with more than 500 receiving stipends.

Social work plays a key role in helping guide the 3 elements of care coordination that are evolving and being implemented in VHA. Social workers coordinate the care of veteran patients in ways that are distinct and do not always involve the direct use of technologies. Social workers, with their training in systems approaches and community linkages, have a long tradition of experiential learning from veterans and their families. That learning is used to address the psychosocial needs of veterans and their families within the context of their support systems and their communities.

Care coordination in VHA emphasizes how the veteran's place of residence should be the preferred place of care whenever this is appropriate for patients and for their formal and informal caregivers. The veteran patient who is admitted to the hospital as an acute emergency with diabetic ketoacidosis may seem to have an undisputed medical problem. However, if ineffective self-management of diabetes and lack of caregiver support are the precipitating causes for this medical emergency, then the problem is psycho-social in nature. This holistic approach is something CCHT specifically seeks to address. The healthcare system has hitherto focused on the care of people in hospitals and latterly clinics. What does a healthcare system look like that relates to patients in their own homes? Social work in VHA has a distinguished history attuning the care the veteran receives to the needs of veterans.

The work of VHA's Office of Social Work in relation to the seamless transition of combat- wounded veterans and with veterans and their families in relation to the VA Fisher House Program exemplifies how VHA Social Work is broadening the scope of what constitutes a healthcare environment for veteran patients.

Seamless Transition

"The Department of Veterans Affairs (VA) has no greater mission, no more important task, than to provide world-class health care for veterans of Operation Iraqi Freedom and Operation Enduring Freedom." *–Jonathan B. Perlin, MD, Under Secretary for Health, US Department of Veterans Affairs*

Social work in VHA played a key role in the evolution of the seamless transition process. Two full-time VHA social workers were assigned to the Walter Reed Army Medical Center, the military treatment facility (MTF) receiving the largest numbers of casualties. In late August 2003, full-time and part-time VHA social workers and Veteran Benefits Administration Veterans Service Representatives were assigned as VA/DoD liaisons to the Brooke, Eisenhower, and Madigan Army Medical Centers, Darnall Army Community Hospital at Fort Hood, and the National Naval Medical Center in Bethesda. The social workers' liaisons worked closely with military medical providers and DoD social workers to assure that returning service members received information about VHA health care benefits and services. They coordinated the transfer of active duty service members and recently discharged veterans to appropriate VA health care facilities. VBA benefits counselors assigned to the MTFs provided information about VA benefits and assistance in filing benefit claims. Through this collaboration, VHA's ability to identify and serve returning service members who sustained serious injuries or illnesses while serving their country was greatly enhanced. Over 1,100 hospitalized soldiers have received assistance from VA social workers. To assure that seamless transition would be available to all service members, the Office of Social Work Service developed a proposal for a permanent Office of Seamless Transition, which was established in VHA in FY05.

The Fisher House Program

This nonprofit foundation was created in 1990 by philanthropists Zachary and Elizabeth Fisher. Although initially focused on military treatment facilities, the work of the foundation has since expanded to include VHA. The first VA Fisher House was built in 1994 at the Samuel S. Stratton VA Medical Center in Albany, N.Y. There are now are seven VA Fisher Houses, with two more under construction.

Fisher Houses provide overnight or extended accommodations for families of hospitalized veterans, similar to Ronald McDonald Houses, a "home away from home" for families of hospitalized children. The realization that family support is a key element in the healing process is intuitive and self-evident to us now, but was not seen as a constituent part of care provision in the past. VHA Social Work oversees the VA Fisher House Program, including serving as liaison to the Fisher House Foundation and providing support and guidance to VA Fisher House managers. Fisher Houses are proving to be vital for family involvement in rehabilitation, particularly with combat-wounded Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF) service members and veterans. The Fisher House Foundation has committed to building two new VA Fisher Houses each year for the indefinite future.

Defining the Relationship of Care Coordination to Existing Care Management and Case Management Endeavors

Supporting the care of patients and their families across the continuum in a way that respects their preferences offers a new vision for healthcare in the 21st Century. VHA is an integrated healthcare system that cares for many special needs populations and is actively operationalizing what a chronic care model looks like in practice. VHA Social Work has played a crucial role in helping define care coordination in terms of the existing care management and case management processes.

Office of Care Coordination
Office of Patient Care Services
Department of Veterans Affairs

http://www.va.gov/occ